DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLÌA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		43A072	B. WING			05/05/2022
NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH PLATTE, SD 57369		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	with 42 CFR Part 483 for Long Term Care fa	h survey for compliance , Subpart B, requirements acilities, was conducted from . Platte Care Center was	F	00		
						VENDATE
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLÉ Administrator	(x6) DATE 5/12/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or hot a film of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. It deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obs MAY 1 2 2022 Event ID: NHSY11

Cordell Muilenburg

Facility ID: 0030

If continuation sheet Page 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		43A072	B. WING		05/05/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETION EAPPROPRIATE DATE
E 000	Initial Comments		E	000	
	CFR Part 482, Subpa Emergency Prepared Term Care Facilities,	ey for compliance with 42 art B, Subsection 483.73, ness, requirements for Long was conducted from 5/3/22 are Center was found in			
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				1	
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	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	ππιε Administrator	(x6) date 5/12/2022

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program participation.

FORM CMS-2567(02-99) Previous Version's Obsolete

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Facility ID: 0030

If continuation sheet Page 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED
		43A072	B. WING _		05/03/2022	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH PLATTE, SD 57369		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	BE COMPLETION
K 000	INITIAL COMMENTS		ΚO	000		
	Life Safety Code (LS occupancy) was cond Center was found in	ey for compliance with the C) (2012 existing health care ducted on 5/3/22. Platte Care compliance with 42 CFR ents for Long Term Care				
	ł.					
ADODATORY	NIDECTOD'S OD DDOVIDED	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE S SIGNATURE	-		E(4.2.12)	100

Cordell Muilenburg

Administrator

5/12/2022

Any deficiency statement ending with an asterist (3) denotes a density which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient provided above are disclosable 90 days following the date of survey whether of 50 a plan of correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 days following the date here deductions are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation. MAY 1 2 2022

SD DOH-OLC

Every ID: KH\$Y21

Facility ID: 0030

If continuation sheet Page 1 of 1

5/12/2022

If continuation sheet 1 of 1

South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 05/05/2022 B. WING 10664 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 E 7TH POST OFFICE BOX 200 PLATTE CARE CENTER **PLATTE, SD 57369** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG \$ 000 S 000 Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/3/22 through 5/5/22. Platte Care Center was found in compliance. S 000 S 000: Compliance/Noncompliance Statement Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/3/22 through 5/5/22. Platte Care Center was found in compliance. (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

H9SE11

MAY 1 2 2022

Cordell Muilenburg

STATE FORM